SELF-ESTEEM AND ADAPTATION/INTEGRATION OF GENDER NON-CONFORMING, TRANSGENDER AND TRANSEXUAL (TRANS*) PEOPLE

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by
Aydin C. Kennedy
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ABSTRACT

SELF-ESTEEM AND ADAPTATION/INTEGRATION OF GENDER
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(TRANS*) PEOPLe

by
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Master of Social Work
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The journey for trans* individuals in self-identifying, disclosing, and transitioning is complex and not well understood. In this study, an online survey was completed by 239 adults who self-identify along the trans* continuum and have medically transitioned. The survey included demographic variables along with items from standardized scales used to measure self-esteem and transgender adaptation and integration. Results showed that the age of identifying, socially transitioning, and medically transitioning were all associated with levels of self-esteem and adaptation. The number of years since both social and medical transition was significantly correlated with scores on self-esteem and adaptation and integration measures. These findings have important
implications for trans* individuals and gatekeepers of the transition process including family members, medical and mental health providers.
CHAPTER I
INTRODUCTION TO THE STUDY

More than 50% percent of transgender youth will have attempted suicide by the age of 20 (Youth Suicide Prevention Program, 2011) and 41% of transgender, transsexual, gender nonconforming (trans*) adults report having attempted suicide at least once in their life compared to 1.6% of the general population (Grant et al., 2011). The ability for trans* individuals to integrate and assimilate into their asserted gender peer group has been found to be a key risk factor for suicide (National Center for Transgender Equality, 2010). Difficulties related to integration and assimilation for this population may result from experiences with oppression and discrimination.

In 2011, a large-scale study was conducted by Grant and colleagues to better understand the forms of discrimination and oppression that trans* individuals experience and the results were alarming. The study found that trans* individuals face higher than typical levels of discrimination in most areas of their lives, including education, employment, and access to social services, as well as housing; they were four times as likely to live in extreme poverty as compared to the general population. However, three out of four respondents in this study indicated that they felt more comfortable in all areas of their lives after they transitioned.

Family and social support may buffer trans* individuals from experiences with discrimination and facilitate successful adaptation and integration into their peer
group and communities. Research conducted by Nuttbrock, Rosenblum, and
Blumenstein (2002) found that higher levels of depression were inversely related to the
amount of support for trans* identity received from friends and family. Brill and Hastings
(2009) noted that “individuals from the fields of medicine, mental health, social work,
and education consistently report the same findings: when supported by their families,
schools, and care providers, transgender youth have the opportunity to thrive and develop
strong self-esteem” (Brill & Hastings, 2009). Little is known, however, about the extent
to which family/social support facilitates a smoother and earlier transition. It is also
unclear if social and psychological adjustment is greater for those who are socially and/or
medically transition at a younger age as compared with those who do so later in life.

The purpose of this study was to gain a better understanding of the
relationship between age of social and/or medical transition and levels of self-esteem,
adaptation, and integration in trans* individuals. It also explored how length of time since
social and/or medical transition is related to self-esteem and adjustment/integration.

Definition of Terms

**Asserted Gender**

The gender/sex that an individual feels she/he is.

**Assigned Sex**

The sex an individual was assigned at birth; female, male, intersex.

**Cisgender**

Someone whose assigned sex is congruent with his/her gender/sex identity.
Coming Out

The process of disclosing one’s sexual and/or gender identity.

Medical Transition

The use of cross sex hormones – testosterone, estrogens – and/or gender related surgeries to facilitated a physical change to one’s body.

SES

Rosenberg Self-Esteem Scale.

Social Transition

The process in which someone begins to externally present themselves as their asserted gender. Can include name change, pronoun change and/or change in physical appearance.

TG-AIM

Transgender Adaptation and Integration Measurement.

Trans*

Transgender, transsexual, transexual, gender queer, gender non-conforming, gender expansive.
CHAPTER II

LITERATURE REVIEW

In 2007 and in 2009 the Massachusetts Behavioral Risk Factor Surveillance Survey was conducted and among other demographic data, trans* identity was gathered. The results of that study indicated that in 2011 there were approximately 700,000 trans* people living in the U.S. (Gates, 2011). Trans* people have been reported in societies and cultures preceding the Middle Ages until the present day (American Psychological Association, 2012). Despite this long history, the experiences of trans* individuals lives remains largely misunderstood, pathologized and, as a result, met with violence.

Discrimination

A national survey was conducted in 2011 to better understand the experiences of trans* individuals in the United States. The results of the survey put into perspective the level to which trans* people are experiencing discrimination. The results of that survey found that trans* people face copious amounts of discrimination in all areas of life including employment, education, family life, housing, public accommodations, police and jails and ID documents (Grant et al., 2011). The degree to which these forms of discrimination are experienced by those with trans* and gender non-conforming identities are reflected in the following findings from Grant et al. (2011):
78% of trans* youth, while in grades K-12, reported being the victim of harassment; 35% reported physical assault, and 12% sexual violence. The harassment was so severe that one-sixth of the respondents had to leave a school.

Trans* people were four times more likely than cisgender people to have a yearly household income less than $10,000.00 and have double the rate of unemployment.

90% reported experiencing harassment, mistreatment or discrimination on the job.

Over half experienced significant family rejection, had higher levels of homelessness and drug or alcohol dependency, and engaged in street economy sex work. Respondents reported a variety of overt housing discrimination.

19% reported having been refused housing.

11% reported being evicted from their home because of their asserted gender.

One-fifth had experienced homelessness at some point in their lives because they were trans* or gender nonconforming.

Over half of those trying to access a homeless shelter were harassed by shelter staff or residents, while 29% were turned away altogether and 22% had been sexually assaulted by residents or staff.

32% reported owning their home compared to 67% of the general population.

19% reported being refused medical care due to their trans* or gender non-conforming status, with people of color reporting this to an even greater extent.
• 50% reported having to educate their medical and mental health providers about trans* care.

• Trans* people had over four times the national average of HIV infection, with rates of this disease higher among trans* people of color.

• One-fifth reported harassment, with much higher rates reported by trans* people of color.

• 50% reported being uncomfortable seeking police assistance.

• 16% of respondents who had been incarcerated reported being physically assaulted and 15% reported being sexually assaulted.

• Of those who are post transition, only one-fifth has updated all of their identity documents with their new gender. One-third of those who were post transition have updated none of their identity documents/records and nearly half live without identity documents that match their asserted gender identity.

The combination of anti-trans* bias and institutional racism was especially catastrophic for trans* people of color. Across the board, African American respondents reported greater disparities in all areas of their lives than White respondents (Grant et al., 2011). Research suggests that those affiliated with stigmatized groups have a higher prevalence of psychiatric difficulties than their dominant counterparts (Chakarborty & McKenzie, 2002; Klonoff, Landrine & Campbell, 2000).

Research has indicated that experiences with discrimination faced by trans* individuals negatively affects psychological functioning even if they have not been victimized directly (Sánchez & Vilain, 2009). Because of the high prevalence of discrimination faced by trans* people, even those who have not directly experienced
violence and discrimination are negatively impacted simply by being part of a targeted group (Sánchez & Vilain, 2009).

Stigma, Anxiety and Depression

Existing research has focused largely on causation and psychopathology of trans* identity, which has been useful for the medical and mental health treatment of trans* individuals. This focus has provided a narrow and pathologizing view of the overall experience of being trans* and has contributed to the stigmatization of trans* individuals (Sánchez & Vilain, 2009). Gender Identity Disorder (GID), the psychiatric and medical diagnosis given to people whose assigned birth sex does not align with their gender identity, was first introduced in the third version American Psychiatric Association Diagnostic and Statistical Manual (DSM) in 1980. As a result, trans* identities in both children and adults have been viewed, not as a natural or normal variation of human experience, but rather as a mental illness. With the 5th edition of the DSM scheduled to be released in May, 2013 (American Psychological Association, 2013), there is speculation the GID will be removed and replaced with Gender Dysphoria and moved out of the paraphilia’s category and into a category of its own (Cameron, 2012). This reclassification, along with the change in title, is considered a significant improvement in the diagnostic coding system that has historically acted as a gate keeper for access to medical transition care (Winters, 2012). However, there is no indication that these changes will remove or decrease the stigma and pathologizing of trans* identities.

The stigma of having a mental illness has compounded the difficulties for trans* individuals in assimilating and integrating their personal identities. Corrigan and
Rafacz (2011) found that some people with psychiatric disorders may internalize the negative stereotypes associated with mental illness leading to lower self-esteem. Sánchez and Vilain (2009) found “the internalization of negative feelings regarding a transsexual identity may be detrimental to one’s well-being” (p. 206). A progressive model leads to a four-stage model of self-stigma contributing to lower self-esteem and hope: “being aware of associated stereotypes, agreeing with them, applying the stereotypes to one’s self, and suffering lower self-esteem” (Corrigan & Rafacz, 2011, p. 339).

Symptoms of depression have been reported to affect between 48% to 62% of the overall trans* population with anxiety and overall distress rates ranging from 26% to 38% (Nemoto, Bödeker & Iwamoto, 2011, as cited in Budge, Adleson, & Howard, 2013). Research has found that gender non-conforming and trans* youth are at a higher risk for victimization during adolescence and increased difficulty with psychosocial adjustment leading to depression, anxiety and suicidality (Toomey, Ryan, Diaz, Card, & Russell, 2010).

Western culture has strict gender performance guidelines, these performance guidelines and expectations start at a very young age, with assigned males having more rigid performance rules. Those who do not adhere to the expected rules of performance of their assigned sex often experience a variety of negative consequences (Toomey et al., 2010). Victimization against gender non-conforming assigned males has been found to occur more often than victimization against gender non-conforming assigned girls (Toomey et al., 2010).
Family Acceptance

In 2006, The Family Acceptance Project (a community research initiative that works to better understand LGBT youth’s experiences of acceptance related to family’s acceptance) examined the links between family acceptance and LGBT youth’s overall mental health. That study, for the first time, established that family acceptance is a key factor in the overall mental health for LGBT youth (Ryan, Russell, Huebner, Diaz, & Sanchez, 2010). The study found that “family acceptance in adolescence is associated with young adult positive health outcomes self-esteem, social support, and general health and is protective for negative health outcomes depression, substance abuse, and suicidal ideation and attempts” (Ryan et al., 2010, p. 210). Research has found that gender identity is developed by the age of three, when children see themselves as either boys or girls (Gosh, 2012). While cisgender people’s development of gender identity and performance falls into the rigid binary constraints and is rarely questioned, trans* and gender non-conforming youth are frequently pathologized and shamed. In fact, they are seen as of incapable of making, what is seen by most, as a prodigious life decision about the incongruence between their gender identity and their assigned sex.

However, as noted above, many of these youth are making even larger life decisions when contemplating suicide as a means of coping. Moreover, the societal tendency to view trans* and gender non-conforming persons as disordered, may contribute to lower levels of family acceptance and increase trans* peoples difficulties with self-esteem, integration and assimilation. As a result of society’s lack of awareness and understanding of trans* identities, family’s often feed into the social rejection and stigmatization, which leads to sexual and physical violence of trans* youth (Brill &
Hastings, 2009). One can argue that with increased knowledge about the importance of family support, the mental health and medical communities are able to better support the youth and their families, positively impacting the mental well-being of trans* youth.

The removal of Gender Identity Disorder from the DSM may decrease the tendency for parents and professionals to view trans* individuals as mentally ill, thereby increasing levels of family support. Spiegel (2008) asserts that “if we allow people to unfold and give them the freedom to be who they really are, we engender health. And if we try and constrict it, or bend the twig, we engender poor mental health.” Brill and Pepper (2008) acknowledge the important role that families play in the psychological health and well-being of youth. As familial support increases, trans* youth are beginning to socially and medically transition at a younger age. As stated by Brill and Hastings (2008), in the past, parents of trans* children may have denied what was happening, allowed their children to socially transition but hid it from others, or prevented their child from living their authentic gender until they left home. They go on to say that awareness of trans* children is increasing, and more parents are becoming more comfortable publically supporting their trans* children at younger ages (Brill & Pepper, 2008).

Because awareness of the trans* community has increased and trans* individuals are becoming more visible at earlier ages (Sánchez & Vilain, 2009), the World Professional Association of Transgender Health (WPATH) has updated their suggested protocols for treatment of trans* youth. This organization provides the standards of care (SOC), which are the clinical guidelines for professionals devoted to helping them safely support trans* people with their goals of living their asserted gender and maximize overall psychological well-being. In the past, treatment of gender
dysphoria in youth involved encouraging them to become more congruent with their assigned sex through dress, play, activities, and other gendered preferences. This course of treatment proved to be unsuccessful, particularly in the long term and is now considered unethical (World Professional Association of Transgender Health, 2012). WPATH now supports earlier social transition for trans* youth and encourages parental support of their trans* children.

Importance of Social and Medical Transition

Research has found that it is not uncommon for an individual to come out as trans* later in life – sixty years or older (Ettner & Wylie, 2013). For those individuals who have not transitioned but have identified as trans*, late adulthood is an especially difficult time of an adjustment. Feelings of isolation, loneliness, shame, lack of support and regrets about the loss of time can create chaos in previously stable individuals (Ettner & Wylie, 2013). Ettner and Wylie (2013) suggest that when trans* individuals transition early, they are usually able to “consolidate their identity by middle and late adulthood” (p., 229). Devore (2004) found social transition to be important in the development of positive trans* identity. He reports that social transition allows for a person to experience witnessing (accurately being seen by others) and mirroring (seeing oneself in others like oneself), the absence of these experiences can lead to psychosocial distress and, when severe, can lead to suicide. Thus, parents have been encouraged to support their children in socially transitioning because of the devastating impact that not being seen as their asserted gender can have on their self-esteem (Brill & Hastings, 2009).
Additionally, there are benefits to allowing a youth to medically transition, which includes natal puberty suppression followed with cross sex hormones. According to Brill and Hastings (2009), this has been found to decrease the likelihood of youth obtaining street hormones or suicide as a means of coping with the emotional agony caused by living in the wrong physical body. These authors assert that the benefits for a trans* youth in going through an affirmed puberty through puberty blockers and cross sex hormones are tremendous (Brill & Hastings, 2009).

An extensive body of research has been done examining the impact of discrimination, violence and oppression has on trans* individuals’ self-esteem and overall life experiences. What has not been examined is if earlier social and medical transition mitigates the prevalence of these experiences. It stands to reason that children whose sense of self is validated at an earlier age may develop higher levels of self-esteem, while children who are shamed for expressing their gender non-conformity may begin to internalize self-loathing.
CHAPTER III

METHODOLOGY

Participants in this study included 239 adults (18 years or older) who self-identified along the trans*continuum and had medically transitioned via puberty blockers, hormones and/or surgery. Recruitment took place via email and the social networking site, Facebook. A brief description of the purpose of the study was provided, along with a link to Survey Monkey where the survey was posted for a three-month period. The link first directed participants to the informed consent page where they were required to give consent before entering the survey. If participants declined to give consent, they were redirected out of the survey. All study procedures and survey questions were approved by The California State University, Chico Institutional Review Board. Participants were not paid for their participation. The survey consisted of 38 questions and was expected to take approximately 30 minutes to complete.

The questionnaire collected demographic information including age, ethnicity/race, assigned sex, current sex, age of identifying as trans*, age of social and medical transition and years since transition. The existing research has found assigned and current gender/sex identity to be directly correlated with higher levels of discrimination, oppression and violence with trans* women of color experiencing all of these at higher rates than their counterparts. There appeared to be gaps in the existing research about the importance of age of social and medical transition and self-esteem and
adjustment. Collecting that data was an important part of this research as well as years since transition. In addition to demographic information, the following standardized scales were used to measure self-esteem and adaptation/integration. Rosenberg Self-Esteem Scale (RSE; Rosenberg, 1979) is a 10-item, 4-point Likert scale ranging from 1 (Strongly Agree) to 4 (Strongly Disagree). The RSE total scores range from 0-30. Those scoring between 15-25 are considered to be within the normal range for self-esteem. Scores below 15 indicate poor self-esteem. Rosenberg’s self-esteem scale has been commonly used with its validity and reliability well substantiated. The Transgender Adaptation and Integration Measure (TG AIM; Sjoberg, Walch, & Stanny, 2006) consists of 15 items, 4-point Likert-type response scale used to measure adjustment for trans* adults, with higher scores reflecting greater adjustment. The measure consists of three subscales, with each demonstrating adequate reliability, Gender-Related Fears (Cronbach alpha = .81); Psychosocial Impact of Gender Status (Cronbach alpha = .72); and Coping and Gender Reorientation Efforts (Cronbach alpha = .73). Gender-Related Fears focuses on concerns related to discrimination, atonement and exposure of gender incongruence. Psychosocial Impact of Gender Status focuses on the effect of gender incongruence on mental health, quality of life and interpersonal relationships. Coping and Gender Reorientation Efforts focus on efforts toward the integration of internal gender identity and assigned sex and anatomy. Validity of overall instrument has been established in research revealing significant correlations with standardized measures of self-esteem and quality of life (Sjoberg et al., 2006).

In analyzing the data, descriptive statistics were used to determine frequencies and/or mean scores for demographic variables including: age, ethnicity, geographical
location, assigned sex at birth, current gender/sex, age of identifying as trans*, age of
disclosure, social transition, and medical transition. T-tests were used to examine
differences in levels of self-esteem and adjustment for participants who were younger
versus older when they identified as trans*, disclosed, socially transitioned and medically
transitioned. T-tests were also used to determine if participants differed in self-esteem
and adjustment based years since identifying as trans*, disclosing, socially transitioning,
and medically transitioning (under three years, versus three or more years). Correlational
analyses were used to examine the relationships between self-esteem/adjustment and
years since socially and medically transitioning.
CHAPTER IV

LIMITATIONS

Several limitations of this study can be identified. First, the investigator’s personal email and Facebook page was used to disseminate the survey, which likely contributed to the over representation of White trans* men. The investigator sought a diverse range of ethnic and racial participants, including those who live outside of the United States. However, there were an extremely low number of respondents living outside of the United States. As previously indicated, the sample was homogenous with an over representation of White trans* men. It is likely that the experiences of White trans* men do not accurately represent those of trans* women nor trans* men and women of color. It would be advantageous for a more inclusive study to be conducted to better understand self-esteem, adaptation and integration.

Previous research has indicated that discrimination, oppression and violence has been especially devastating for trans* women of color. Gathering data with respect to these experiences from all of the respondents may have allowed for a better understanding of how they impact self-esteem, adaptation and integration across trans* individuals.

Furthermore, there was a lack of important data collection such as yearly income, which may be an indicator of access to transition related services. It is likely that those who earn less are less able to access services to facilitate medical transition
impacting self-esteem, adaptation and integration. Because medical transition was a requirement to participate in the study, the voices of those who had not, cannot, or do not wish to medically transition were left out, potentially gathering data only from the most privileged portion of the trans* community.

In addition, data about the respondents’ perceptions and direct experiences of family support and/or rejection was not gathered. There is strong evidence that suggests family support is crucial in the positive development of trans* children and adults. Without this information, there is no way to know if the majority of participants had family support, which may have impacted their self-esteem, adaptation and integration scores. Not gathering data from trans* individuals who are under the age of 18 may have impacted the results of the study assuming that self-esteem, adaptation and integration increases with maturity and life experience.

Also, because no data was collected regarding discrimination, oppression, and violence there is no way to know if self-esteem and adjustment scores were positively or negatively affected by those experiences.

There were also limitations related to the measurements used for this study. Rosenberg’s Self-Esteem Scale, although widely used, gathered information without consideration of one’s specific experiences with self-esteem related to being trans*, nor did it collect data about one’s perceptions of self-esteem prior to socially and/or medically transitioning. Also, it is not certain if this measurement tool is generalizable to the experiences of non-White individuals. Future research should consider the multiple factors listed above that may contribute to trans* individuals’ self-esteem, adaptation and integration.
CHAPTER V

RESULTS

Within the overall sample, \(N = 239\), the majority of respondents, 67% were assigned female at birth, and 31% were assigned male at birth (see Figure 1). Participants’ ages ranged from 18 to 65 with the mean age being 34 \(SD = 12\). A large majority (80%) identified as White/Caucasian, 8% as Native American/First Nations, 6%

*Figure 1. What sex were you assigned at birth?*
as Latino/Latina, and 5% as Bi/Multicultural (see Figure 2). Participants were allowed to select more than one gender identity, 165 respondents were assigned female at birth with

![Figure 2. Which category best describes your race/ethnicity?](image)

43% identifying as male, 44% as transgender male, and 28% as transsexual male. Of the 74 respondents who were assigned male at birth, 13% identified as female, 20% as transgender female and 16% as transsexual female. Eleven percent identified as genderqueer and 8% as gender non-conforming (see Figure 3). Twenty-nine percent of the respondent’s identified as trans* by the age of five with 74% of the sample identifying as trans* by the age of 18. The minimum age of identifying was 3 and the
maximum was 65, with the mean age being 13 ($SD = 10.5$). However, only 50% had disclosed their trans* identity by the age of 25, and 75% disclosed by age 35.

The minimum age of disclosure was age three, and the maximum was 66, with the mean age being 27 ($SD = 11.5$). The minimum age of social transition was three years and the maximum was 65, with the mean age being 27.6 ($SD = 11.3$). The minimum age of medical transition was 14 and the maximum was 65, with the mean age of medical transition being 31.9 ($SD = 11.1$). Slightly over fifty-five percent of respondents were more than two years post social transition (see Figure 4) and 54% were within their first two years of medical transition (see Figure 5).
Roughly 85% of respondents lived in the United States, with 40% living in California. Fourteen percent reported living outside of the United States. Just under half (46%) identified living in an urban area, 22% in a suburban area, 20% in a small town and 11% living in a rural area (see Figure 6).

Data analysis continued with t-tests aimed at identifying differences in self-esteem and adjustment based on age of self-identifying as trans* and age of disclosure. Respondents who first self-identified as trans* under the age of 17 reported having higher levels of Coping and Gender Reorientation skills than those who self-identified at an older age ($t = -2.03; p = .043$) with mean scores of 13.6, ($SD = 3.43$) and 7.6 ($SD = 3.50$), respectively. However, respondents who self-identified as trans* after the
age of 17 reported having higher levels of self-esteem than those who self-identified at a younger age \((t = -2.048; p = .042)\), with mean scores of 21.2, \((SD = 6)\) and 19.5 \((SD = 6.22)\) respectively. They also reported having fewer Gender-Related Fears \((t = -2.08; p = .038)\) with mean scores of 8.5 \((SD = 3.19)\) and 7.6 \((SD = 3.50)\) and decreased Psychosocial Impact of Gender Status \((t = -4.29; p = .000)\) with means scores of 6.3 \((SD = 2.38)\) and 4.9 \((SD = 2.58)\) respectively. Age of disclosure was not significantly related to self-esteem or adaptation and integration.

No significant differences were found in self-esteem or adjustment/integration, based on age of social transition. However, age of medical transition appeared relevant. Those who medically transitioned after the age of 17 had higher
Figure 6. Which category best describes where you currently live?

self-esteem scores ($t = -2.99; p = .003$) with a mean score of 21 ($SD = 5.83$) as compared with 18.5 ($SD = 6.5$) for those who medically transitioned at a younger age. They also scored higher in Coping and Gender Reorientation skills ($t = -5.56; p = .000$) with a mean scores of 14.3 ($SD = 2.8$), as compared with 11.9 ($SD = .422$) for those who medically transitioned earlier. In addition, they had overall higher TG-AIM scores ($t = -3.87; p = .001$) with a mean score of 27.7 ($SD = 5.3$), as compared with 24.5 ($SD = .798$) for those who medically transitioned at a younger age.

Scores for respondents who were three or more years post social transition were higher in two of the three subcategories of the TG-AIM, overall TG-AIM scores, as well as self-esteem than those who were three years or less post social transition. They
reported having decreased Gender-Related Fears ($t = -3.93; p = .000$), decreased Psychosocial Impact of Gender Status ($t = -2.37; p = .018$), and increased overall TG-AIM score ($t = -4.01; p = .000$). Higher levels of self-esteem were also reported for this group ($t = -3.20; p = .001$) with a mean score of 20.9 ($SD = 6$) as compared with 18.4 ($SD = .703$) for those who had more recently transitioned socially.

Not surprisingly, years since medical transition were significantly related to self-esteem and adjustment. Those who were three years or more post medical transition reported having decreased Gender-Related Fears ($t = -4.10; p = .000$), decreased Psychosocial Impact on Gender Status ($t = -1.94; p = .000$) and higher Coping and Gender Reorientation skills ($t = 10.89; p = .000$) than those who more recently transitioned. The total TG-AIM score was also significantly higher for this group ($t = -8.72; p = .000$). Their mean total score was 27.8 ($SD = 5.09$), as compared with 19.5 ($SD = 6.75$) for those who more recently transitioned. Overall self-esteem scores were also found to be higher for those who were more than three years post medical transition ($t = -2.99; p = .003$) with a mean score of 20.5, ($SD = 6.02$), as compared with 17.5 ($SD = 6.57$) for those who had transitioned within the last three years.

Correlational analysis was also conducted to examine the relationships between years since transition and self-esteem and adjustment/integration. A significant yet fairly low positive correlation was found between years since social transition and self-esteem ($r = .200; p = .001$) and adaptation and integration skills ($r = .217; p = .001$). A significant, yet fairly low positive correlation, was also found between years since medical transition and self-esteem ($r = .225; p = .000$). A moderate and significant positive correlation was found between years since medical transition and adaptation/
integration ($r = .39; p = .000$). These findings suggest that the longer it has been since an individual socially and medically transitioned, the better off they will be in terms of self-esteem, adaptation, integration. One can argue that when individuals are able to socially and medically transition at a younger age they are likely to enjoy greater self-esteem and adjustment over their life span.
CHAPTER VI

DISCUSSION AND IMPLICATIONS

The purpose of this research was to determine if the age of social and/or medical transition was positively associated with later life self-esteem, adaptation, and integration. This study was also focused on examining the relationships between time since social and medical transition and these same dependent variables.

American Academy of Pediatrics (2011), asserts that children become aware of being a boy or a girl within the first year of life and by the age of four children are able to identify themselves as either a boy or a girl. For trans* and gender expansive children, this is the same time in which they may become aware of a conflict between their assigned sex and gender identity. It is important to challenge the heteronormative, heterosexist and cisgender privileged paradigm which punish individuals who do not fit into the narrow social expectations of gender presentation and performance. This paradigm can be particularly destructive for those who are assigned male at birth. When a child’s gender performance and identity deviate from the social norms and expectations of their assigned sex, he or she are often subjected to discrimination, oppression and ridicule (American Academy of Pediatrics, 2011). Previous research has overwhelmingly confirmed that trans* woman experience discrimination, oppression and violence at much higher rates that their trans* male counterparts.
It is also important to note that in a patriarchal society there are greater rewards, such as male privilege, for trans* men than there are trans* women. This is likely to hold true across ethnic and racial identities. Challenging this paradigm may foster an environment where trans* individuals can experience acceptance at earlier ages allowing for more affirming and celebrated transition and enhanced adjustment and self-esteem over the life span.

Most of the research thus far has focused on how mental health professionals, medical practitioners, and parents can better support trans* individuals and their loved ones. The research and literature has also made clear that trans* people experience higher rates of discrimination, poverty, family rejection, homelessness, poor medical care, higher HIV rates, increased depression and anxiety, and suicide than their cisgender counterparts. It is hoped that the quality of life may be enhanced for these individuals as researchers and service providers gain a better understanding of the age and time sequencing between identifying as trans*, disclosing one’s trans* identity, socially and/or medically transitioning, and, finally, the acquisition of high self-esteem and adaption/integration.

In the current study, there was a 14 year difference between age of trans* identification and disclosure. This may indicate the presence of oppression during a vulnerable stage of life when identity development is crucial. Age of disclosure and age of social transition appeared roughly the same which might be expected considering that social transition often occurs when trans* people come out to their friends, family and peers. It is not surprising that individuals who self-identified at a younger age had made more progress toward Coping and Gender Reorientation as they had more time to
reconcile the incongruence of their physical body with their identity. It is also important to note, however, that individuals who identified at an older age scored higher in self-esteem and reported decreased Psychosocial Impact on Gender Status, Gender-Related Fears and overall TG-AIM scores. This may be due to a greater level of physical and emotional maturity on the part of these individuals. It may also be that they had more family and peer support and greater access to the trans* community, as well as stable financial resources. Another factor to consider is the small sample size of individuals who transitioned under the age of 18 and the lack of any data from individuals who are currently transitioning and are under the age of 18. The data indicated that the age of social transition had less of an impact on self-esteem and adjustment than age of medical transition. Again, the small sample size of people under the age of 17 may have contributed to these findings.

This study also found that once an individual socially transitioned, they quickly began medically transitioning. This is not surprising considering the sample was homogenous with the majority of respondents being White males in their mid-30s and almost half lived in urban areas. Transition related services tend to be more accessible for this group of individuals in general and more available in urban areas. It is likely that being able to quickly transition after coming out would impact one’s self-esteem as well as his or her adaptation and integration skills. However, research is needed to confirm this hypothesis.

Another central finding of this study was that overall self-esteem and adjustment scores were higher for those who medically transitioned after the age of 17. It is important to consider that an older individual may be better equipped because he or she
is financially, socially, psychologically and emotionally more mature to handle large life changes. Transition impacts all areas of life.

The study also indicated that the number of years since social transition and years since medical transition were found to be important variables impacting self-esteem and adjustment. Those who were three years or more years post medical transition reported higher levels of self-esteem and were better adjusted. The findings of the correlation analysis confirmed this as well. Social transition is an important step in navigating this process, as is medical transition with the early introduction of cross sex hormones (testosterone or estrogens). Preventing the development of natal puberty eliminates the need for future surgeries to remove secondary sex characteristics such as breasts, body hair, and Adams apple. The continued affirming experiences of being witnessed and mirrored may increase the probability of higher self-esteem, adaptation and integration and minimize experiences of social stigma and discrimination. It is important to note that youth who transition at a younger age arrived at the three-year post transition mark at an earlier age than older individuals and may have experienced better self-esteem and adjustment over the life span. Those who were within the first two years of medical transition reported lower levels of self-esteem and this indicated a greater struggle with adjustment. This information can be used to better understand the importance of medical, mental health, family and peer support during this fragile time of identity development.
CHAPTER VII

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

This study explored the relationships between age of social/medical transition, time since transition, and self-esteem and adjustment for trans* adults. The study found that individuals who identified at a younger age had better Coping and Gender Reorientation skills, yet scored lower in all other areas of self-esteem and adjustment. It also indicated that the longer an individual has to adjust to the incongruence of their assigned sex with his or her asserted gender identity, the better he or she may feel about themselves. However, individuals who identified at a younger age scored lower in all other areas of self-esteem and adjustment.

The study found that the years since transition were positively correlated to self-esteem and adjustment. Mental health providers need to be aware of the suggestions provided in the standards of care that help facilitate medical transition, the new diagnostic criteria for treating trans* youth as well as medical transition options for them. Empowering and educating parents and caregivers about the importance of family support to their child’s self-esteem and adjustment may contribute to earlier and more successful social and medical transitions. This may allow individuals to arrive at the 3-year post transition mark earlier, also furthering greater self-esteem and adjustment throughout their lifetime.
Historically, the emphasis on mental health support has been prior to one’s medical transition focusing on pre-transition mental stability. Although this study did not gather data specific to the importance of pre-transition mental health services, the data did reveal that it is equally, if not more important, for one to have mental health support during the first two years of transition. It is also important that mental health and medical providers, as well as family, friends and partners recognize that support for trans* people is crucial within the first two years of transition. Understanding this point helps us move from a diagnostic gate keeping perspective towards a person-centered approach to working with trans* individuals.

Support is vitally important in helping individuals to carefully consider decisions related to when they will disclose and socially and/or medically transition. Family members and service providers need to appreciate the significant amount of time that frequently lapses between the age of identifying as trans* and disclosing. They need to also understand the importance of this stage of development, as it increases comfort with being trans*.

Future studies are needed to examine the reasons trans* individuals wait for a relatively long period of time between identifying and disclosing. This may be important in guiding parents and caregivers in providing necessary support and acceptance. Additionally, more inclusive research needs to be done to better understand the experiences of trans* youth who have socially and medically transitioned under the age of 18 and trans* individuals living outside of urban areas. This information may allow for a better understanding of their transition process and factors that contributed to positive coping versus maladaptation. Evaluating the effectiveness of pre-transition mental health
services is also important. Lastly, researchers must access the most vulnerable members of the trans* community, trans* women of color, to gain a deeper understanding of how experiences with violence, oppression and discrimination, are impacting their self-esteem. This information is vital to the overall understanding of the experiences of trans* individuals.
REFERENCES
REFERENCES


http://www.yspp.org/about_suicide/statistics.htm
Table A1

Comparison of Mean Scores By Age of Identifying

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*p ≤ .05, **p ≤ .01, ***p ≤ .001
Table A2

Comparison of Mean Scores By Age of Disclosure

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*p ≤ .05, **p ≤ .01, ***p ≤ .001
Table A3

*Comparison of Mean Scores By Age of Medical Transition*

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*p ≤ .05,  **p ≤ .01,  ***p ≤ .001
Table A4

*Comparison of Mean Scores By Years Since Social Transitions*

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*p ≤ .05, ** p ≤ .01, ***p ≤ .001
Table A5

*Comparison of Mean Scores By Years Since Medical Transitions*

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* *p ≤ .05, ** p ≤ .01, *** p ≤ .001*